

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

Lawrence

County

Township ~~Forest Park~~ Pine

Village

City

Registration District No. 471

Primary Registration District No. 5634

File No. 138065

Registered No. 136

FULL NAME

Leroy Clifton Embanks

[If death occurred in a hospital or institution, give its NAME instead of street and number]

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

SEX

Male

COLOR OF RACE

White

SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

—

DATE OF DEATH

Nov 9, 1916
(Month) (Day) (Year)

DATE OF BIRTH

June 9, 1908
(Month) (Day) (Year)

AGE

7 yrs. 6 mos. — ds.
If LESS than 1 day, ___ hrs. or ___ min.?

I HEREBY CERTIFY, that I attended deceased from Nov 6, 1916, to Nov 9th, 1916, that I last saw him alive on Nov 9th, 1916, and that death occurred, on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH* was as follows:

Obstruction of Intestines

122B

OCCUPATION

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

BIRTHPLACE

(City or town, State or foreign country) Lawrence Co. Mo.

(Duration) yrs. — mos. 6 ds.

Contributory

(SECONDARY)

(Duration) yrs. — mos. — ds.

(Signed) Carlos Copeland M. D.

Nov 10, 1916 (Address) Monett Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

Where was disease contracted if not at place of death? —

Former or usual residence —

PLACE OF BURIAL OR REMOVAL Arnold Chapel Cem DATE OF BURIAL 11-10- 1916

UNDERTAKER None ADDRESS —

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carlos Copeland

(ADDRESS) Monett Mo.

Filed 11-11- 1916 W. West REGISTRAR

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonæum*, etc., *Carcinoma, Sarcoma*, etc. of (name origin; "Cancer" is less definite; avoid

use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart-disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW

PLACE OF DEATH
Linn
County
Pence
Township
Village
City

Registration District No. *471* File No. *1*
Primary Registration District No. *5634* Registered No. *136*
St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

FULL NAME *Leroy Clayton Eubanks*

PERSONAL AND STATISTICAL PARTICULARS

SEX *M* COLOR OR RACE *W* SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) *S*

DATE OF BIRTH *June 9 1908*
(Month) (Day) (Year)

AGE *7* yrs. *13* mos. *5* ds.
If LESS than 1 day... hrs. or... min.?

OCCUPATION
Trade, profession, or particular kind of work

General nature of industry, business, or establishment in which employed (or employer)

PLACE (City or town, State or foreign country) *Mo. 1014*

NAME OF FATHER *Mr Eubanks*

BIRTHPLACE OF FATHER (City or town, State or foreign country)

MAIDEN NAME OF MOTHER *Miss Mordy*

BIRTHPLACE OF MOTHER (City or town, State or foreign country) *Mo*

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *A W Crossland*

(Address) *Moret Mo*

Filed *11/11* 191*6* *J. B. Barshie* Registrar

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH *Nov 9 1916*
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from *Nov 6 1916* to *Nov 9 1916*

that I last saw him alive on *Nov 9 1916* and that death occurred, on the date stated above, *12:25 a.m.*

THE CAUSE OF DEATH* was as follows:

Obstruction of Intestines
104
Duration *3* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary)

(Signed) *Carlos Copeland* M. D. *11/10* 191*6* Address *Moret Mo*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted if not at place of death?

Former or usual residence?

19 PLACE OF BURIAL OR REMOVAL *Woodl Chappell Care* DATE OF BURIAL *11-10 1916*

20 UNDERTAKER *None* ADDRESS

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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Tuberculosis of lungs, meninges, peritonaeum, etc., Carcinoma, Sarcoma, etc. of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or inter-current) affection need not be stated unless important. Example: *Measles (disease causing death), 29ds.; Bronchopneumonia (secondary), 10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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